PREMIER WOMEN'S HEALTH, LLC

NAME DATE

CONSENT FOR TREATMENTS

CONSENT TO TREAT

By signing this consent, I am authorizing my physician and/or other individuals she deems appropriate to perform and/or order exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Premier Women's Health unless revoked by me verbally or in writing.

Patient/ Legal Representative Signature Date

WELL WOMAN EXAM CONSENT

The American College of Obstetricians and Gynecologists explains the need for an annual assessment as a fundamental part of medical care to promote prevention practices recognize risk factors for disease, identify medical problems and establish the clinician-patient relationship. The annual health assessment should include screening, evaluation, counseling and immunizations based on age and risk factors. Performance of a physical examination is a key part of an annual health assessment visit. The components of that examination may depend on age, risk factors and physician preference.

Every insurance plan has different stipulations and/or guidelines that must be met. Premier Women's Health, LLC leaves the responsibility to you as the patient to understand what your insurance will and will not cover for your annual well woman exam. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. As your physician, I believe that certain services are an important part of your medial care and recommend that you receive these services as part of your current treatment plan. However, in the event the services are not considered to be covered benefits under your health insurance you will be personally responsible for the payment of such services. The purpose of this notice is to help you make and informed choice about whether or not you want to receive these items or services that may or may not be covered by your health insurance.

Patient/ Legal Representative Signature Date

NON-COVERED SERVICES

I acknowledge that I have been informed in advance of receiving services at Premier Women's Health that may or may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges.

Patient/ Legal Representative Signature Date

Relationship to Patient

*** * * This form must be signed by the patient or legal guardian *PRIOR* to receiving any services. * * ***